APPLICATION FOR PARTICIPATION AND MANAGEMENT PLAN FOR SPONSOR OF AFFILIATED CHILD OR ADULT CARE CENTERS CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

NOTE: ONLY COMPLETE IF AGENCY WILL SPONSOR TWO OR MORE CHILD OR ADULT CARE CENTERS WHICH ARE LEGALLY AFFILIATED WITH AGENCY AND WHICH ARE UNDER THE SUPERVISION AND DIRECT CONTROL OF AGENCY'S GOVERNING BOARD AND/OR CHIEF ADMINISTRATIVE OFFICER.

1A. **NAME OF SPONSOR:**

1B. **CACFP AGREEMENT NO.:**	1C. **FEDERAL EMPLOYER IDENTIFICATION NUMBER FOR CENTER:**
03-47- _____ *	_____
***If applying for first time, CACFP Agreement No. will be assigned by Department of Human Services.**	

2. **MAILING ADDRESS:**

_____

Street City State Zip Code

COUNTY LOCATION OF CENTRAL OFFICE: _____

3. **CONTACT INFORMATION:**

Telephone Number:	Fax Number:	E-Mail Address:
Area Code: ( ) _____	Area Code: ( ) _____	_____

4. **NAME AND TITLE OF PERSON WHO MAY BE CONTACTED FOR CACFP INFORMATION:**

5A. **FOR PRIVATE NON-PROFIT, PUBLIC OR CHURCH CENTER ONLY:**

Name of Executive Director:	Home Address of Executive Director:	Date of Birth of Executive Director:
Name of Board Chairperson:	Home Address of Board Chairperson:	Date of Birth of Board Chairperson:

5B. **FOR PROPRIETARY (PRIVATELY OWNED) SPONSOR ONLY:**

Name of Owner (Or Name/Title of Corporate Representative):	Home Address of Owner (Or Corporate Representative):	Date of Birth of Owner (Or Corporate Representative):

6. **SPONSOR ELIGIBILITY** (Check only one):

____ Private Non-Profit (agency has federal income tax exemption) ____ Public (agency is affiliated with governmental unit)

____ Church sponsored (agency is affiliated with church) ____ Proprietary (agency is privately owned and operated for profit)

7. **FOR PRIVATE NON-PROFIT SPONSOR ONLY:**

Please attach photocopy of letter of federal income tax exemption from the Internal Revenue Service.

8. **FOR CHURCH AFFILIATED SPONSOR ONLY:**

Please attach a letter from the Chairman of the Governing Board or Pastor which authorizes this application. In addition, please attach a copy of letter from Tennessee Department of Revenue which documents state sales tax exemption for the church.

9. **FOR PUBLIC OR PRIVATE NON-PROFIT SPONSOR WITH GOVERNING BOARD OF DIRECTORS ONLY:**

Attach a copy of minutes of Board meeting in which CACFP application was approved.

10. **RECEIPT OF FEDERAL FUNDS:**

Did the total federal funds received by the agency through the State of Tennessee and expended during the agency's prior fiscal year, **and** the total federal funds received by the agency directly from the federal government and expended during the agency's prior fiscal year exceed $500,000: ____ Yes ____ No **(Do not include any vendor child care payments received under the Tennessee Child Care Certificate Program in this determination.)**

If the total federal funds exceeded $500,000, the agency is required to have an audit of the funds to participate in the CACFP.

11. **OPERATION OF CACFP IN OTHER STATES:**

Does your agency operate the CACFP in any other state(s) ___ Yes ___ No (If YES, please identify each state):

_____

_____

_____

12. **BUDGET:**

Complete the attached budget. The budget will be reviewed to determine if adequate personnel are available to administer the program.

13. **APPLICATION FORMS AND SUPPORTING DOCUMENTS FOR CHILD OR ADULT CARE CENTERS:**

Attach the following application forms and documents for each sponsored center:

A. HS-1964A application form for each non-pricing child care center, HS-1964B application form for each pricing child care center, HS-1964C application form for each non-pricing adult care center, and HS-1964D application form for each pricing adult care center;

B. A current child or adult care license for each center, as appropriate;

C. A copy of the income eligibility application form and parent/guardian letter to be used for each child or adult care center,

D. Copies of menus for each new center to participate, and

E. For any sponsored proprietary center, attach copy of most recent DHS -EAV, **OR** copies of Child Care Certificates for at least 25% of enrollment, **OR** copies of completed income eligibility applications for free or reduced-price participants.

14. **SUMMARY OF INFORMATION FOR SPONSORED CENTERS:**

Complete "Exhibit 1" for each center to participate in the CACFP. Complete additional copies of "Exhibit 1", as necessary, to provide information for all centers now sponsored.

15. **MONITORING REVIEWS OF SPONSORED CENTERS:**

A sponsoring agency must ensure that the meals services of each sponsored center is monitored subject to the following requirements: (1) Each center must be visited at least three times each program year to complete the monitoring reviews; (2) The monitoring visits to each center must occur not more than six months apart; (3) One of the required monitoring visits for each center must occur during the first four weeks of CACFP operations; (4) At least two of the monitoring visits to each center must be unannounced; and (5) The findings of all monitoring visits must be identified in written reports which are maintained for inspection by state and federal personnel.

To ensure that adequate staff are available to perform the monitoring responsibility, a sponsor must have one Full-Time Equivalent staff year devoted to monitoring for every 25 – 150 sponsored centers. A Full-Time Equivalent (FTE) staff year is the amount of work that one person working full-time (i.e., 40 hours per week) would perform in a year. Each monitoring position must be located within 100 miles of the centers to be monitored by the position. **If 25 or more centers will be sponsored**, please provide the information requested below, including the FTE of each position which is devoted to the monitoring function. (Attach additional sheets if necessary.)

Name	Position Title	Office Location	No. of Centers Assigned to Position for Monitoring	Is Office Location within 100 Miles of All Centers to be Monitored	FTA for Monitoring
					No. of Hours Worked Each Week to Perform Monitoring Reviews: _____ Divided by 40 = _____ FTE for Position.
					No. of Hours Worked Each Week to Perform Monitoring Reviews: _____ Divided by 40 = _____ FTE for Position.
					No. of Hours Worked Each Week to Perform Monitoring Reviews: _____ Divided by 40 = _____ FTE for Position.
					No. of Hours Worked Each Week to Perform Monitoring Reviews: _____ Divided by 40 = _____ FTE for Position.

Total Full-Time Equivalents for Monitoring: _____

16. **FACILITIES AND PARTICIPANTS:**

Identify the number of sponsored facilities and participants:

TYPE OF FACILITY:	NUMBER OF CENTERS:	NUMBER OF PARTICIPANTS:
Private Non-profit or Public Child Centers		
Private Non-profit or Public Adult Centers		
Proprietary Centers		
Outside School Hours Child Care Centers		
TOTALS (FOR ALL CENTERS)		

17. **TOTAL ENROLLMENT BY ELIGIBILITY CATEGORY FOR ALL SPONSORED CENTERS:**

Identify the total enrollment by eligibility category for the participants served by all centers under your sponsorship:

Number of Participants in Free Category: _____

Number of Participants in Reduced-Price Category: _____

Number of Participants in Paid Category: _____

TOTAL (For All Centers): _____

18. **NEWS RELEASES**

Each agency approved for CACFP participation must distribute news releases announcing its participation in the program. Identify below the names of the local news media, minority or other grassroots organizations to receive these news releases. The news releases are to be distributed after approval for CACFP participation is received from the Tennessee Department of Human Services. Your agency is **not** required to have the news releases published in newspapers as a legal notice.

IDENTIFY LOCAL NEWS MEDIA, MINORITY AND GRASSROOTS ORGANIZATIONS TO RECEIVE NEWS RELEASES:
1.
2.
3.
4.

19. **EMPLOYEES TO REVIEW PARTICIPANT ELIGIBILITY APPLICATIONS:**

Identify below the agency employees who will be designated to review participant eligibility applications and to make determinations of participant eligibility for free and reduced price meal reimbursements:

_____ Name and Title	_____ Name and Title
_____ Name and Title	_____ Name and Title

20. **FOR PUBLIC OR NON-PROFIT SPONSOR WITH GOVERNING BOARD OF DIRECTORS ONLY:**

Identify the name, address and telephone number of each member of your Board of Directors. (**Not required for state colleges and universities or sponsoring agencies which are proprietary entities.**) Attach additional sheets if necessary.

NAME:	ADDRESS:	TELEPHONE NUMBER:

21. **OUTSIDE EMPLOYMENT POLICY:** Attach your agency's outside employment policy. The policy must restrict other employment by employees that interferes with an employee's performance of CACFP related duties and responsibilities, including outside employment that constitutes a real or apparent conflict of interest.

22. **EMPLOYEES TO SIGN REIMBURSEMENT CLAIMS:**

Enter the name, title, and signature of the employees authorized to sign claims:

Name and Title	Signature
Name and Title	Signature
Name and Title	Signature
Name and Title	Signature

23. **TRAINING OF EMPLOYEES PERFORMING CACFP DUTIES** (Training for each employee performing CACFP duties must be provided at least once per program year):

Identify your agency's anticipated date(s) for in-house training for the program year beginning October 1 and ending September 30.

Month	Day	Year
Month	Day	Year
Month	Day	Year

24. **BOOKKEEPING/ACCOUNTING SERVICE:**

Identify the name and address of any bookkeeping or CPA firm used to perform accounting functions for the CACFP:

25. **FINANCIAL VIABILITY (FOR NON-GOVERNMENTAL SPONSORING AGENCY ONLY):**

Please include one of the following documents with your application:

A. A copy of a "Letter of Credit" from your banking institution that identifies available credit that is equal to (or greater than) the reimbursement received by your agency for an average two-month period during the last twelve months; or

B. A copy of the letter entitled "Independent Auditor's Report" that is contained in an audit report for your agency that is not more than two years old; or

C. A copy of your agency's most recent checking accounting statement; or

D. A copy of a financial statement for your agency's last business year which is signed and dated by an authorized representative and which identifies the following:

(1) Assets (cash, securities, real estate, etc.),

(2) Liabilities (notes payable, mortgages, other liabilities, etc.),

(3) Total annual expenditures for all programs and activities of the agency, and

(4) Total annual income from all sources received by the agency.

26. **MANAGEMENT CONTROLS FOR PROGRAM ACCOUNTABILITY (FOR NON-GOVERNMENTAL SPONSORING AGENCY ONLY):**

Please complete, sign and date the attached **Sample Form to Document Required Management Controls** and return it with your application.

27. **CLAIM EDIT CHECKS:**

To be approved for CACFP participation, your agency must have claim edit checks in place to ensure the following:

(1) Each center is paid only for those meal types for which it has been approved to serve under the CACFP;

(2) The number of meals claimed by each center does not exceed the number derived by multiplying approved meal types times days of operation times enrollment; and

(3) All block claims are detected. A block claim is a claim in which the number of meals claimed by a center for one or more meal types is identical for 15 consecutive days within a claiming period.

Does your agency have these edit checks in place: ___ Yes ___ No How are they performed: ___ Manually ___ Automated
(If applying as a new sponsoring agency, please check "No")

28. **CIVIL RIGHTS COMPLIANCE** (Answer each question for your agency's Civil Rights Compliance):

Does your agency sponsor facilities regardless of race, color, national origin, sex, age, or disability? ____ Yes ____ No

Is membership in any organization a prerequisite for sponsorship? ____ Yes ____ No If yes, what is organization's name?

_____

Does your agency have procedures for handling complaints? ____ Yes ____ No

Has your agency received any discrimination complaint(s)? ____ Yes ____ No

If discrimination complaint(s) have been received, attach information describing what action has been taken.

CERTIFICATION STATEMENT

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE ; AND THAT I AM AUTHORIZED BY THE AGENCY TO APPLY FOR PARTICIPATION IN THE CACFP. I ALSO CERTIFY THAT THE AGENCY WILL ACCEPT FINAL ADMINISTRATIVE AND FINANCIAL RESPONSIBILITY FOR THE CACFP OPERATED AT THE FACILITIES IDENTIFIED HEREIN; THAT THE AGENCY WILL ADMINISTER THE CACFP IN FULL COMPLIANCE WITH THE FEDERAL GOVERNING REGULATIONS FOUND IN 7 CFR PART 226, AND THE STATE POLICIES CONTAINED IN OPERATIONAL MANUALS AND POLICY MEMORANDA ISSUED BY THE TENNESSEE DEPARTMENT OF HUMAN SERVICES. I FURTHER ASSURE THE TENNESSEE DEPARTMENT OF HUMAN SERVICES THAT THE FOLLOWING ACTIONS SHALL BE TAKEN:

1. REIMBURSEMENT WILL ONLY BE CLAIMED FOR THOSE MEALS AND SUPPLEMENTS SERVED TO ELIGIBLE PARTICIPANTS; AND THAT THE MEAL SERVICE WILL BE AVAILABLE TO ALL ELIGIBLE PARTICIPANTS REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE OR DISABILITY;

2. ALL ELIGIBLE PARTICIPANTS IN THE CACFP MEAL SERVICES WILL BE SERVED THE SAME MEAL(S) AT NO SEPARATE CHARGE REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE OR DISABILITY; AND THAT THERE SHALL BE NO DISCRIMINATION IN THE COURSE OF THE MEAL SERVICES;

3. ONLY THOSE MEALS THAT ARE APPROVED IN THIS APPLICATION BY THE TDHS AND THAT MEET FEDERAL AND STATE REQUIEMENTS FOR FOOD COMPONENTS AND PORTION SIZES SHALL BE CLAIMED FOR REIMBURSEMENT;

4. THAT THE NUMBER OF MEALS CLAIMED FOR REIMBURSEMENT SHALL NOT EXCEED THE MAXIMUM ALLOWED UNDER THE CACFP; AND THAT APPROPRIATE AND ADEQUATE RECORDS, INCLUDING MENUS, ATTENDANCE AND MEAL COUNT RECORDS SHALL BE MAINTAINED TO SUPPORT THE NUMBER AND TYPE OF MEALS REPORTED TO THE TENNESSEE DEPARTMENT OF HUMAN SERVICES FOR CACFP REIMBURSEMENT;

5. THAT A PUBLIC RELEASE SHALL BE PROVIDED TO THE INFORMATIONAL MEDIA SERVING THE AREA(S) FROM WHICH PARTICIPANTS LIVE; AND THAT MINORITY AND GRASSROOTS ORGANIZATIONS IN THE SERVICE AREA(S) OF THE AGENCY ARE INFORMED OF THE ADULT OR CHILD CARE SERVCIES AVAILABLE FROM THE AGENCY;

6. ALL REQUIRED ELIGIBLITY APPLICATIONS ARE CURRENT; AND THAT FAMILY SIZE AND INCOME DOCUMENTATION SHALL BE MAINTAINED ON AN ANNUAL BASIS, AND WHENEVER THERE IS A CHANGE IN ELIGIBLITY CRITERIA;

7. ALL DOCUMENTATION CONCERNED WITH ELIGIBLITY APPLICATIONS SHALL BE MAINTAINED FOR AT LEAST THREE YEARS AFTER THE END OF THE CACFP FISCAL YEAR TO WHICH THE DOCUMENTATION PERTAINS, UNLESS IT MUST BE HELD PENDING FOR A LONGER TIME FOR AN AUDIT RESOLUTION PURPOSE; AND

8. NO INCOME INFORMATION CONCERNING PARTIPANTS WILL BE SHARED WITHOUT THE WRITTEN CONSENT OF THE PARENTS OR GUARDIANS, AND ACCESS TO AND USE OF THIS INFORMATION WILL BE LIMITED TO AUTHORIZED PERSONS EMPLOYED BY THE AGENCY.

I ALSO CERTIFY THAT THE AGENCY HAS PARTICIPATED IN THE FOLLOWING PUBLICLY FUNDED PROGRAMS DURING THE PAST SEVEN YEARS AND THAT NEITHER THE AGENCY NOR ANY OF ITS PRINCIPALS ARE INELIGIBLE TO PARTICIPATE IN THESE PROGRAMS BY REASON OF VIOLATION OF THE REQUIREMENTS OF THESE PROGRAMS DURING THAT PERIOD:

LIST OF PUBLICLY FUNDED PROGRAMS: _____

_____

_____

I FURTHER CERTIFY THAT NEITHER THE AGENCY OR ANY OF ITS PRINCIPALS HAVE BEEN CONVICTED OF ANY ACTIVITY THAT OCCURRED DURING THE PAST SEVEN YEARS AND THAT INDICATED A LACK OF BUSINESS INTEGRITY. CONVICTIONS INDICATING A LACK OF BUSINESS INTEGRITY INCLUDE FRAUD, ANTITRUST VIOLATIONS, EMBEZZLEMENT, THEFT, FORGERY, BRIBERY, FALSIFICATION OR DESTRUCTION OF RECORDS, MAKING FALSE STATEMENTS, RECEIVING STOLEN PROPERTY, MAKING FALSE CLAIMS, AND OBSTRUCTION OF JUSTICE.

I UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN IN CONNECTION WITH THE RECEIPT OF FEDERAL FUNDS, AND THAT A DELIBERATE MISREPRESENTATION MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE STATE AND FEDERAL CRIMINAL STATUES. I ALSO UNDERSTAND THAT ANY AGENCY AND INDIVIDUALS PROVIDING FALSE CERTIFICATIONS WILL BE PLACED ON THE USDA NATIONAL DISQUALIFIED LIST AND WILL BE SUBJECT TO ANY OTHER APPLICABLE CIVIL OR CRIMINAL PENALTIES.

NAME, TITLE AND SIGNATURE OF AGENCY BOARD CHAIRPERSON, CHIEF EXECUTIVE OFFICER OR OWNER:

Name (Please Print)	Title
Signature (Do Not Print)	Date

"EXHIBIT 1"

INFORMATION FOR CENTERS SPONSORED

County: _____

NAME AND ADDRESS OF EACH CENTER	TYPE OF CENTER C = Child Care Center A = Adult Care Center O = Outside School Hours Center F = For-Profit Center	LICENSE CAPACITY	NO. OF SHIFTS	IDENTIFY MEALS TO BE CLAIMED: Breakfast = B AM Snack = AM Lunch = L PM Snack = PM Supper = S Evening Snack = ES					
				B	AM	L	PM	S	ES

HS-1965A (Revised 6/08 - All Other Forms Obsolete)

SAMPLE FORM TO DOCUMENT REQUIRED MANAGEMENT CONTROLS FOR SPONSOR OF AFFILIATED CHILD OR ADULT CARE CENTERS

As mandated by the federal regulation at 7 CFR Part 226.6 (b) (18), each new or renewing sponsoring agency must have a financial system with written management controls. To document the management controls utilized by your agency, please provide the following information:

1. What is the frequency for depositing all cash receipts (including checks) at your banking institution:

   _____

2. Who is authorized to perform the following:

   a. Receive all child care fees from parents and guardians;

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   b. Deposit all cash receipts (including checks) at your banking institution:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   c. Open the mail:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   d. Review the CACFP budget (approved by the Tennessee Department of Human Services) before incurring costs that are charged to the program:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   e. Review vendor invoices for correctness of the quantities received and prices charged before payment is made:

      Name: _____ Position Title: _____

Name: _____ Position Title: _____

f. Ensure that pre-numbered checks are utilized for the payment of all costs:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

g. Record all checks when issued:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

h. Safeguard all unused checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

i. Retaining all voided checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

j. Ensure that no checks are issued payable to cash:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

k. Mail checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

l. Receive statements and cancelled checks from your banking institution:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

m. Reconcile monthly bank statements:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

n. Review reconciled bank statements:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

o. Review monthly statements for outstanding balances owed:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

p. Approve, sign, and distribute payroll checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

q. Prepare monthly CACFP claims for reimbursement:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

r. Contact the Tennessee Department of Human Services on all CACFP claims that are <u>not</u> paid within 30 days of submission;

Name: _____ Position Title: _____

Name: _____ Position Title: _____

3. Who is responsible for ensuring that all labor costs charged to the CACFP are supported by Time and Attendance Records which identify the starting time, ending time, and absences for each working day in each pay period:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

4. Who is responsible for ensuring that Time Distribution Records are maintained for all employees who perform both CACFP operational and administrative duties, or duties for the CACFP and other programs.

Name: _____ Position Title: _____

Name: _____ Position Title: _____

5. Who is responsible for ensuring that payroll records are maintained for each employee charged to the CACFP:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

The payroll records must include the following information:

a. Employee name;

b. Rate of pay;

c. Hours worked;

d. Benefits earned;

e. Any reductions or increases to the employee's base compensation, such as overtime pay;

f. Gross pay;

g. Net pay;

h. Date of payment;

j. Method of payment, such as check or electronic funds transfer; and

k. Verification that employee has been paid, such as canceled checks or electronic funds transfer deposit verification.

6. Describe the procedures for employees to request and receive approval for annual and sick leave;

_____

_____

7. Who has access to the personnel files of employees:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

8. Who is responsible for maintaining an inventory of all equipment purchased with CACFP funds:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

The CACFP defines equipment as an item of non-expendable personal property with a useful life of more than 1 year and an acquisition cost of $5,000 or more per unit.

NAME AND TITLE OF AUTHORIZED SPONSOR OFFICIAL:

_____ _____

NAME TITLE

SIGNATURE OF AUTHORIZED SPONSOR OFFICIAL:

_____ _____

SIGNATURE DATE

PUBLIC RELEASE FOR
CHILD AND ADULT CARE FOOD PROGRAM

_____ announces participation in
(NAME OF SPONSORING AGENCY)

the Child and Adult Care Food Program. Meals will be provided at no separate charge to eligible children served at the following site(s):

NAME:	ADDRESS:

All meals will be provided in accordance with the U.S. Department of Agriculture non-discrimination policy which prohibits discrimination based on race, color, national origin, sex, age and disability. (Not all prohibited bases apply to all programs.)

The income eligibility guidelines for free and reduced price meals are attached.